SSAB Safeguarding Adults Review Subgroup

Terms of Reference

Date Agreed: July 2021
Date of Next Review: July 2022

Purpose

The Care Act 2014 places a statutory duty on Safeguarding Adults Boards (SABs) to undertake SARs in the circumstances described at Section 44. The Care and Support Statutory Guidance (section 14.133 onwards) sets this out in more detail. More specific supporting local guidance on SARs can be found in the Stockport SAR Protocol..

The SAR subgroup acts with delegated responsibility from the Stockport SAB. Its' main purpose is to monitor the delivery of its statutory duties with regards to carrying out SARs and other reviews of cases where there are lessons to be learnt around how relevant agencies may have acted differently to prevent harm or death, and advising the SAB on the lessons to be learnt.

Function

The key objectives of the SAR Subgroup are to:

- Ensure an effective multi-agency Stockport SAR Protocol is in place and in line with the Stockport Safeguarding Adults Policy and Procedures and compliant with the requirements of the Care Act 2014.
- Receive referrals and consider cases that may require a SAR (whether mandatory or discretionary) and to make recommendations to the SAB Independent Chair.
- Commission SAR reviewers, identify stakeholders / partners to be involved in the SAR, agree terms of reference and costs associated with each review.
- In line with Making Safeguarding Personal, ensure all reviews consider the involvement of the adult and/or the family/carer(s).
- Initiate other multi-agency partnership reviews or single agency reviews on cases, other than SARs, when it is considered that there may be lessons to be learnt in safeguarding adults at risk of abuse and/or neglect.
- Receive updates on the progress of SARs and consider the final SAR report and recommendations, ensuring this in line with the SAR Quality Markers, before submitting this to the SAB for sign off. (See Appendix 1)
- Develop, monitor and review SAR and partner agency action plans, and feed this into quarterly updates to the SAB.
- Ensure links are established and maintained with other Boards and processes where required, for example, criminal investigations, coronial investigations, Domestic Homicide Reviews (DHRs), Learning Disabilities Mortality Review (LeDeR) Programme, Child Safeguarding Practice Reviews (CSPRs) and reviews into drug-related deaths. This will include periodic attendance from colleagues from other Boards to provide relevant updates and share parallel learning across processes.
- Ensure all SARs are published on the website (whether redacted or in full) along with learning briefings and action plans, and that learning themes are shared with the Stockport SABs, National Board Managers Network, and other relevant local and national forums.
- Raise awareness of the SAR Protocol and learning from SARs with staff in all SAB agencies.

Membership

Membership will include core representation from the statutory members of the SAB (i.e. Adult Social Care/ Stockport NHS Clinical Commissioning Group / Greater Manchester Police) and the following additional members:

Stockport Safeguarding Business Unit	Head of Safeguarding and Learning (Chair)
Adult Social Care (ASC)	Head of Adult Safeguarding and Principal Social Worker
Greater Manchester Police (GMP)	Detective Sergeant, Strategic Safeguarding Team
Stockport NHS Clinical Commissioning Group (CCG)	Designated Nurse Safeguarding Adults
Stockport NHS Foundation Trust (SNHSFT)	Head of Safeguarding
SAB	SAB Development Manager

Each of the core members will nominate a deputy of sufficient seniority to fully act on behalf of the agency they represent, if they are unable to attend any meeting.

Designated members can be agreed, dependent upon the issue under discussion, and where their input will enhance the subgroup's discussions and effectiveness of actions.

The meeting must have quorate membership of one representative from each of the statutory agencies, i.e. ASC, Police and CCG.

Within the subgroup, members are expected to:

- Contribute to the development of the subgroup as an effective, efficient and inclusive team.
- Raise concerns with the Chair as necessary.
- Share responsibility with partners for ensuring delivery of the work planned.
- Be responsible and accountable for delivering the subgroup's objectives through its' Work Plan.
- Participate in meetings both as a member of the SAR Subgroup and as a representative of their agency.

Chairing arrangements

The SAR subgroup will be chaired by the Head of Safeguarding and Learning, with the representative of ASC acting as deputy chair.

Links with other subgroups

The SAR subgroup will link to other SAB subgroups where they have an important role to plays in matters such as:

- Sharing learning and development needs identified through SARs with the Training and Workforce Development Subgroup.
- Initiate audit activity that may stem from SAR recommendations with the Performance and Quality Audit Subgroup.
- Sharing any communication and public interest matters from SARs to ensure that partners are aware of any implications for their organisation.

Meeting frequency and form

The SAR Subgroup will meet on a planned monthly basis. Meetings can be cancelled if there is no substantive business to discuss with at least 24 hours' notice given where possible.

Meetings will be held virtually via MS Teams or held at Stockport Town Hall.

The SAB Business support Officer and SAB Development Manager will provide administrative support to the subgroup.

An agenda and papers for the meeting will be sent a week in advance of the meeting date. Members are expected to read papers in advance of meetings and have copies of relevant papers for reference within the meetings. Minutes will be kept of all meetings and circulated to the members after the meeting.

The subgroup may establish task and finish working groups with co-opted members from partner organisations to undertake specific activities in relation to SAR activity.

The referring person / agency will be invited to attend the SAR Subgroup to present their referral and be involved in the discussions on the case.

Decisions and escalation

Wherever possible, the subgroup will make decisions and recommendations based on consensus between members. Where there is not consensus, decisions will be made based on one vote per statutory partner.

In exceptional circumstances, where consensus cannot be reached, issues can be escalated to the SAB Independent Chair to provide direction.

Where decisions are required urgently outside of formal meetings these can be reached via email correspondence.

Accountability

The SAR Subgroup is accountable to the SAB and will report quarterly to the Board. The subgroup will collate an overview of all the cases that have been considered by the subgroup and SAR activity for inclusion in the SAB Annual Report.

Confidentiality and Data Protection

The subgroup will communicate with members electronically in accordance with the Stockport Information Sharing Protocol, and compliance with the Data Protection Act 2018 and GDPR regulations.

All matters discussed at the SAR Subgroup will be confidential, and unless agreed, should not be divulged to other parties. All agendas, reports and other documents shall be treated as confidential unless and until they become public in the ordinary course of the Board's business. However, if information is discussed that would prejudice the welfare of the person(s) concerned and/or others, it will be the responsibility of the Chair to ensure that such information is handled appropriately.

Review

The TOR will be reviewed on an annual basis.

SAR Criteria

A SAR should always be considered if:

- an adult has died (including death by suicide), and abuse or neglect is known or suspected to be a factor in their death;

  or

- an adult has experienced serious abuse or neglect which has resulted in permanent harm, reduced capacity or quality of life (whether because of physical or psychological effects), or the individual would have been likely to have died but for an intervention;

  and

- there is concern that partner agencies could have worked more effectively to protect the adult.

  If the SAR criteria are not met but the relevant SAB feels that there are lessons to be learnt, an alternative review may be undertaken.

Independent Reviewer Report Checklist

Reports should:

- Ensure a Making Safeguarding Personal approach, written with a focus on the individual, recording their hopes, wishes, fears etc.
- Be produced in clear / plain English and be fully checked for spelling / typos and grammar. Reports should not use emotive, inflammatory, blaming / shaming language or identify specific staff or identifiable teams in agencies. Abbreviations or acronyms, if used, should be explained in full in the first instance.
- Be balanced & focussed on facts, analysis, conclusions, & recommendations.
- Note whether the Review is mandatory or discretionary.
- Be clear about the category of abuse & if there is an interface between these e.g. there are often links between Neglect & Acts of Omission &, Physical & Psychological/Emotional abuse.
- Reference good practice and any obstacles to this. The Report should reference work undertaken by agencies, prior to the Review, to mitigate against risks.
- For shortfalls please comment on why these may have occurred in terms of systems or practice issues.
- Consider and report on ethnicity and protected characteristics and the impact of these and, any discriminatory abuse/factors.
- Consider the impact of the National Context e.g. Government Policy, other potentially influencing factors such as the economic climate.
- Consider themes in the context of other similar local and / or national reviews.
- Information from the IMR forms will be collated and sent to you by the SAB Development Manager.
- The final report should contact a summary of key events and commentary on this.

Recommendations must be:

- SMART: Specific, Measurable, Achievable, Realistic & Timebound.
- Clear on whether it is a Board action or, for a specific agency is to take forward.
- Reasonable and have a clear evidence basis with reference to findings in the Review.
- The SAR Subgroup / panel may consider if recommendations are SMART and may request amendments.

Timescales:

Best practice guidance is for a review to be completed within 6 months and where extension to timescales are required a clear rationale should be provided and realistic target dates set, within the principle of no delay.

Appendix 1 STOCKPORT SAR QUALITY MARKERS CHECKLIST

SAR Quality Markers are a benchmarking tool to support those who commission, conduct and quality assure SARs. They cover the whole process with the aim of providing a consistent approach to producing good high-quality SARs.

The Markers assume the principles of Making Safeguarding Personal as well as the Six Principles of Safeguarding that underpin all Adult Safeguarding work: Empowerment, Prevention, Proportionate, Protection, Partnership, Accountability.

ROLES AND RESPONSIBILITIES OF SAR SUB-GROUP*

- Scrutinise and analyse information provided, to support the group in making recommendations to the SAB Independent Chair
- Coordinate additional information from own agencies as required, to make a recommendation about whether to commission a SAR.
- Coordinate chronology from own agency
- Determine SAR methodology
- Agree draft Terms of Reference
- Agree draft scoping period
- Confirm organisations to be involved in the review. Confirm initial membership of panel or learning event etc (dependent on the review methodology)
- Approve any changes to Terms of Reference and scoping period
- Approve any changes to panel membership
- Ensure that relevant members of own organisation (including Board Member, IMR author, SAR Panel Member) are updated about commissioned SARs (including sharing review timeline, terms of reference, emerging learning as appropriate)
- Quality assure final draft of Overview Report, Executive Summary and Action Plan, ensuring that the review is of a sufficiently high standard and that wherever possible, multi-agency actions are SMART and have allocated action owners
- Ensure own organisation is adequately represented at relevant meetings (i.e. Case Review Subgroup meetings, SAR/IMR panel meetings, SAR publication meetings) and in key discussions
- Ensure that individual agency learning from SARs is shared within own organisation and that assurance is provided to the Case Review or Training Sub-Group, and the SAB
- Be the main point of contact within own organisation for single agency SAR actions updates

Setting Up the Review

Quality Marker 1: Referral The case if referred for a Safeguarding Adult Review (SAR) consideration with an appropriate rationale and in a timely manner		
Checklist	**Yes/No**	**Comments/Further actions**
Does the referral explicitly identify how the SAR criteria has been met?		
Does the referral specify clearly any other reason why a SAR is needed?		
Does the information provided evidence the rationale given for why the case is being referred?		
Are explanations provided for any delays in the referral?		

Quality Marker 2: Decision Making – What kind of SAR / Enquiry Factors related to the case AND the local context inform decision making about whether a SAR is needed and initial thinking about its size and scope		
Checklist	**Yes/No**	**Comments/Further actions**
Is the rationale for the decision clear and defensible, paying close attention to the Care Act 2014 and Making Safeguarding Personal principles?		
Have all key agencies provided information about their involvement? (Consider other SAB areas)		
Has intelligence from other quality assurance and feedback sources been gathered e.g. audits/benchmarking, complaints and previous SARs? Has this been used to identify outstanding learning needs locally, as well as what is already known and does not need to be re-learnt?		
Have other review pathways been considered/discounted (e.g. DHRs), and have parallel processes been identified (e.g. complaints)?		
Have SAB member agencies had the opportunity to contribute to the decision-making process and recommendation to the Chair?		
Are the decision-making processes and outcomes transparent, and has independent challenge been considered?		
Are explanations provided for any delays in decision making?		

Quality Marker 3: Informing the Person, their family and other important networks The person, relevant family members and any other important personal networks are told what the SAR is for, how it will work, the parameters, how they can be involved, being mindful of treating them with respect.		
Checklist	**Yes/No**	**Comments/Further actions**
Has the person, relevant family members, friends/network been informed of the SAR at the earliest opportunity?		
Has the purpose, process and parameters of the SAR been communicated in the most appropriate way to promote understanding?		
Have you agreed with the family their preferred methods and timeliness of communication throughout the process (verbal, written)?		
Are opportunities offered to discuss queries about the SAR?		

Quality Marker 4: Clarity of Purpose The Safeguarding Board / Partnership is clear and transparent from the outset that the SAR Process is statutory with the focus on learning and improvement across organisations and acknowledges any factors that complicate this		
Checklist	**Yes/No**	**Comments/Further actions**
Have you communicated with all relevant parties (SAB members, involved agency/provider/commissioner leaders, practitioners, Legal advisors) about the statutory purpose of the SAR with a focus on learning and organisational development?		
Has there been a multi-agency discussion regarding any tensions and complications?		
Is the decision-making rationale clearly documented on all records?		

Quality Marker 5: Commissioning Decisions about the precise form and focus of the commissioned SAR consider a range of factors in order to make the learning and improvement proportionate. Decisions are made with input from the SAB Chair, members and reviewers. Have discussions about the form and focus of SAR to be commissioned considered the following:		
Checklist	**Yes/No**	**Comments/Further actions**
Are there any system conditions leading to poor safeguarding practice or communication?		
Do other quality assurance and feedback sources (e.g. audits/complaints) suggest the practice issues and/or their systemic causes are new, complex or repetitive?		
Are any of the issues relevant to the SAB strategic plan and current/future priorities?		
Has similar learning been identified previously, and has this been implemented or is there new learning to be identified?		
Is there evidence of good practice and supportive system conditions, which can be shared across the partnership?		
Are there any issues regarding the capacity of practitioners, SAB and member agencies, and experienced/qualified reviewer(s)?		
Does the process allow the reviewer(s) to influence the scope, nature and approach of the review?		
Is there media interest or serious public concern around the circumstances of the case?		
Principles of Making Safeguarding Personal and the six core safeguarding principles?		

Running the Review

Quality Marker 6: Governance The SAR achieves the requirement for independence AND ownership of the findings by the Safeguarding Board / Partnership and member agencies		
Checklist	**Yes/No**	**Comments/Further actions**
Are senior managers being kept up to date about the learning being identified?		
Are there mechanisms in place to allow challenge to the information and analysis of the review, so that the findings/ recommendations have been thoroughly considered before the report is finalised and taken to the SAB?		
Are there clear governance arrangements in place from the outset of the process? Has the system for quality assurance of the process and sign-off of the report been set out clearly from the start?		

Quality Marker 7: Management of the Process The SAR is effectively managed. It runs smoothly and is concluded within a timely manner and within available resources.		
Checklist	**Yes/No**	**Comments/Further actions**
Are there any issues in relation to key personnel, administrative support or reviewer capacity, that may impact on quality and timings of the SAR?		
Are mechanisms in place to inform the SAB Chair of any delays and reasons for them?		

Quality Marker 8: Parallel Processes Where there are parallel processes the SAR is managed to avoid as much as possible; duplication of effort, prejudice to criminal trials, unnecessary delay and confusion to all parties, including staff, the person and their family.		
Checklist	**Yes/No**	**Comments/Further actions**
Have you agreed the most appropriate process for the circumstances?		
Can parallel processes be utilised for TOR's and scoping to avoid any duplication and repetition?		
Is there defined agreed ownership of SAR documents?		
Is there an index of SAR material and agreement on arrangement for disclosure?		
Where necessary, are there early discussions with the police, CPS, coroner to consider any information relevant to criminal proceedings?		

Quality Marker 9: Gathering Information The SAR gains sufficient quality information to underpin the analysis of the case in context of normal working practices and relevant organisational factors		
Checklist	**Yes/No**	**Comments/Further actions**
Are the aims of the SAR clear?		
Have all avenues of information gathering been considered?		
Does the SAR allow for full inclusion and engagement (person, families, practitioners, multi- agency partners)?		
Are there clear expectations in respect of gathering information – what specific information and level of detail is needed from people and paperwork and why?		
Is there an escalation pathway in respect of non-engagement by participating agencies?		

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Is there an escalation pathway in respect of non-engagement by participating agencies?		

Quality Marker 10: Practitioner Involvement The SAR enables practitioners and managers to have a constructive experience of taking part in the review.		
Checklist	**Yes/No**	**Comments/Further actions**
Does the SAR process express the value and importance of practitioner input and promote an open learning culture to all?		
Is the purpose of practitioner input clear and understood?		
Are practitioners and managers provided with adequate support and protections within their organisations to take part in the SAR Process?		
How will you gather feedback from all those involved in relation to the process?		
What arrangements are in place to thank people for their involvement once the SAR is complete?		

Quality Marker 11: Involvement of the Person, Family and relevant network The SAR is informed by knowledge and experience of the person, family and relevant network regarding the period under review.		
Checklist	**Yes/No**	**Comments/Further actions**
Is there a clearly documented decision process for involvement / non-involvement of the person / family?		
Who will be the specific point of contact with the person / family and what are the arrangements to support them throughout the process?		
Is there clarity about what the family will be asked?		
How are the family to be represented in the final report and how do they provide feedback?		
Where there are criminal proceedings, has a discussion taken place with the police (Senior Investigating Officer) around the family involvement with the SAR Process?		

Quality Marker 12: Analysis The SAR analysis is transparent and rigorous. It evaluates and explains professional practice in the case, highlighting challenges, themes and learning in relation to practitioners' efforts to safeguard adults.		
Checklist	**Yes/No**	**Comments/Further actions**
Are the Six Core Safeguarding Principles and Making Safeguarding Personal reflected in the evaluation of safeguarding practice of this case?		
Does the review take into consideration cultural, organisational and systems practice?		
Does the review highlight any issues around service delivery?		
Is current, up to date research evidence about good practice used in the analysis?		
Does the analysis have clear conclusions in relation this case and the wider safeguarding practice?		
Are you promoting the value of identifying the range of learning (whether good or bad practice) that the case reveals?		
Is information from contributing agencies fully and fairly represented in the report?		

Outcomes and Impact

Quality Marker 13: The Report The report clearly and succinctly identifies the analysis and findings while keeping details of the person to a minimum. Findings should reflect causal factors, systems learning, single and multi- agency learning.		
Checklist	**Yes/No**	**Comments/Further actions**
Does the report meet the requirements of the commissioned specification?		
Is the tone and choice of words appropriate and is the report written in a way that is to the point, understandable and useful?		
Have the person / family had opportunity to comment and is there any legal advice required about publication?		
Does the report sufficiently protect the privacy of the person, family members and practitioners whilst still being accessible and able to support future practice improvement?		
Can the report be used to inform the work of the partnership to improve safeguarding outcomes and prevent future abuse and neglect?		

Quality Marker 14: Improvement Action The Board / Partnership encourages robust informed discussion and agreement from multi-agency partners in respect of action to be taken in response to the SAR Report.		
Checklist	**Yes/No**	**Comments/Further actions**
How will you promote open and constructive challenge in relation to the findings of the report?		
Are there any implications for the SAB / Partnership strategic plan?		
What is the most effective response to the findings and how will individuals and organisations be engaged in this?		
Are there any findings that can be addressed regionally, nationally or in other forums and how will you do this?		
What are the arrangements for sharing, monitoring and evaluating the recommendations in order to ensure learning is embedded and effective?		

Quality Marker 15: Board / Partnership Written Response The Board / Partnership response is clear, accessible, reflects the process, and takes into consideration the required learning and recommendations. It should include information about what has already been done to improve and enhance services and practice and what remains to be achieved		
Checklist	**Yes/No**	**Comments/Further actions**
Is there a clear communication plan involving all the relevant agencies and partnerships?		
Is there an agreement across organisations around the process for disclosure, publication and timescales in order to minimise any duplication or impact upon other reviews / criminal proceedings?		
Where will the Board / Partnership response be shared		

and is it to the point and easy to understand?		
Are the person / family / practitioners aware of the timeline and content of the Board / Partnership response and how will any feedback be recorded and actioned?		
Does the Board /Partnership response include reference to what improvements have been made and what learning is still to be progressed and implemented?		

Quality Marker 16: Publication **The Board / Partnership should refer to statutory guidance to evidence the influence of decision to publish or not and take into consideration the risk to the individual's anonymity. Consideration should be given to the use of Executive Summaries and Learning Briefs.**		
Checklist	**Yes/No**	**Comments/Further actions**
Can the Board / Partnership provide the rationale for the decision around publication / non- publication of the review and this is clearly documented?		
Has the person / family member been fully involved in the decisions around publication and have their views have been considered and discussed? Have they been informed in advance of the report publication?		
Is there a clear multi-agency communications strategy and is there an identified Lead Officer?		
Have key questions and responses been considered to enable a consistent response to media interest.		
Is there is a clear agreement in relation to content and timeframe for release, ensuring where appropriate, the anonymity of those involved?		
Are there any other issues that would prevent publication of the full report? (community tensions, criminal proceedings, media interest)		
Does the publication date clash with any other important dates or activities? (anniversaries, criminal trials, media interest?		
Has the SAR Regional Learning Template been completed for the case to be recorded in the Regional SAR Library?		

Quality Marker 17: Implementation and Evaluation **The SAR findings should inform effective implementation of any system changes. The impact of the SAR Findings should be evaluated to ensure they positively influence practice and improve safeguarding of adults.**		
Checklist	**Yes/No**	**Comments/Further actions**
Has the Board / Partnership actioned the findings and recommendations and evaluated the impact?		
Have the SAR findings been communicated and embedded in multi-agency training and guidance?		
Does the Board / Partnership utilise performance data to evidence and evaluate the impact of learning?		
Has any good practice been highlighted and shared?		
Has the learning been shared locally, regionally and where appropriate escalated nationally?		
Has any regional learning been identified through the		

North East SAR Library and if so how will this be progressed?		
Where learning has been identified previously – is there a clear strategy to embed and revisit this learning?		
Is there a process to revisit the learning, and seek assurance this has been embedded in practice at future intervals?		